

Charlotte Hungerford
Hospital

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Approved
9/26/18
SHN

September 21, 2018

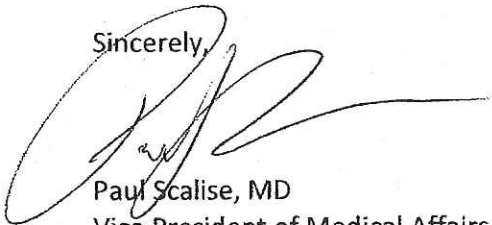
Susan H. Newton, RN, BS
Supervising Nurse Consultant
Department of Public Health
Facility Licensing Investigation Section
410 Capitol Avenue, MS #12 FLIS
P.O. Box 340308
Hartford, CT 06134-0308

Dear. Ms. Newton:

Enclosed please find the Charlotte Hungerford Hospital's response to the letter of violation dated September 10, 2018.

Should you have any questions or require additional information, I can be reached at 860-496-6611 or at pscalise@hhchealth.org. Kate Betancourt, Director of Quality, can be reached at 860-496-6347 or at kbetancourt@hchhealth.org.

Sincerely,



Paul Scalise, MD
Vice President of Medical Affairs

Charlotte Hungerford Hospital
Plan of Correction for
Violation Letter Dated September 10, 2018

Tag/Violation	Defined Measures to Prevent Reoccurrence	Completion Date
<p>Violation # 1a:</p> <p>The following is a violation of the Regulations of Connecticut State Agencies <u>Section 19-13-D3 (b) Administration (2) and/or (e) Nursing Service (1) and or General (6).</u></p> <p>*Based on a clinical record review, facility documentation and interviews for one of three sampled patients receiving oxygen in the ED, the hospital failed to ensure that a portable oxygen tank had a sufficient amount of oxygen for patient use resulting in a change in the patient's oxygen saturation level requiring intubation.</p>	<p>Responsible person:</p> <p>Vice President of Patient Care Services</p> <p>Action Items/Implementation Plan:</p> <p>Immediate Actions:</p> <ol style="list-style-type: none"> On 7/23/18, communication was sent by the Administrative Director of Nursing to all Emergency Department RNs reinforcing that when administering oxygen via a portable tank to patients in the Emergency Department: <ol style="list-style-type: none"> Always utilize a new, full tank Admit patient to a treatment room as soon as possible Reassess oxygen tank status frequently On 7/24/18, Interim Guidelines for Use of Portable Oxygen Tanks in the Emergency Room Department were developed, with a mandatory acknowledgement/sign-off required. On 7/25/18, the identified issue was reviewed at the Quality Assessment and Performance Improvement Committee meeting. On 7/31/18 during the organizational daily safety huddle, a Safety Alert re: monitoring oxygen tank status was reviewed with all leaders in attendance. On 7/31/18, an email was sent to clinical leadership with a written safety alert on oxygen tank monitoring, as well as hospital policy for transporting patients with oxygen, for review and forwarding to their teams. The alert included a job aide to assist clinical staff in gauging the length of time an oxygen tank will last, based on delivery flow rate. On 8/1/18, hard copies of the Safety Alert were provided to leadership during daily safety huddle with instructions to review the alert during unit-based huddles and to post in staff areas. On 8/6/18 the identified issue was reviewed at the Medical Executive Committee. <p>Additional Actions:</p> <ol style="list-style-type: none"> Policy # 100.016, Transporting Patients with Oxygen, will be updated to include expectations regarding verification and monitoring of tank status. On 9/26/18, the identified issue will be reviewed at the Board of Directors meeting. 	<p>7/23/18</p> <p>7/24/18</p> <p>7/25/18</p> <p>7/31/18</p> <p>7/31/18</p> <p>8/1/18</p> <p>8/6/18</p> <p>9/21/18</p> <p>9/26/18</p>

Tag/Violation	Defined Measures to Prevent Reoccurrence	Completion Date
	<p>3. A mandatory HealthStream module on oxygen safety, including revised policy language for tank status verification, will launch on 10/1/18. Training completion date will be 12/3/18</p> <p>Ongoing Monitoring Plan:</p> <ol style="list-style-type: none"> Starting in October 2018, 5 random weekly audits will be conducted by the Respiratory Therapy team to confirm that: <ol style="list-style-type: none"> Oxygen tank storage is consistent with policy (proper segregation of full/post use oxygen tanks) Oxygen tank status is adequate for patient need and being monitored by personnel when in use. Weekly audits will continue until 4 consecutive weeks demonstrate 100% compliance on both parameters. Thereafter, quarterly audits will be conducted x two to confirm that performance is sustained. <p>Where Reported:</p> <ol style="list-style-type: none"> Results will be reported out at the QAPIC meetings until auditing concludes. 	<p>12/3/18</p> <p>10/31/18</p> <p>Ongoing</p> <p>Ongoing</p>
<p>Violation # 2a:</p> <p>The following is a violation of the Regulations of Connecticut State Agencies <u>Section 19-13-D3 (b) Administration (2)</u>.</p> <p>Based on a clinical record review, facility documentation and interviews for one of three patients reviewed for grievances, the facility failed to ensure efforts were made to provide a resolution.</p>	<p>Responsible person:</p> <p>Director of Patient Experience</p> <p>Action Items/Implementation Plan:</p> <p>Immediate Actions:</p> <ol style="list-style-type: none"> On 5/25/18, the Director of Patient Experience met with staff and reviewed expectations to provide an interim update or to close grievances regardless of pending communication from the patient or his/her representative. On 7/23/18, the preliminary finding from DPH related to delayed closure of a grievance was reported to the QAPIC and recommendation was made to report metrics on timely grievance closure to QAPIC on a monthly basis. As of 8/22/18, the metric "percent of grievances closed within 30days" was added to the standing regulatory report. <p>Additional Actions:</p> <ol style="list-style-type: none"> Starting the week of 9/24/18, a weekly review process will be initiated to confirm closure (or interim communication) on any grievance due for closure within the subsequent 7 days. A tracking log will be utilized to capture the review process. 	<p>5/25/18</p> <p>7/23/18</p> <p>8/22/18</p> <p>9/24/18</p>

Tag/Violation	Defined Measures to Prevent Reoccurrence	Completion Date
	<p>Monitoring:</p> <ol style="list-style-type: none"> 1. Monthly review of percent grievances closed within 30 days will be continued until 3 consecutive months of $\geq 100\%$ compliance has been sustained. Thereafter, 2. Quarterly audits will be performed and reported to QAPIC. <p>Where reported:</p> <ol style="list-style-type: none"> 1. CHH QAPIC, minutes of which are submitted to the Northwest Regional Board of Directors 2. CHH Grievance Committee 	<p>Ongoing</p> <p>Ongoing</p>